4. Hospital-specific base year operating costs are divided by the hospital's base year case-mix index and the number of base year Medicaid discharges, and if applicable, the hospital's indirect medical education factor.

10-010.03B4 Calculation of Peer Group Base Payment Amount: Peer group base payment amounts are calculated as a percentage of the weighted median of case mix adjusted hospital-specific base year operating costs per discharge, inflated to the midpoint of the rate year using the MBI. The peer group case-weighted median is determined and is multiplied by a percentage:

1. For metro acute care hospitals, the percentage is 85%;
2. For other urban acute care hospitals, the percentage is 100%;
3. For rural acute care hospitals, the percentage is 100%.

10-010.03B4a Consideration for Hospitals that Primarily Service Children: Effective January 1, 1997, a hospital qualifies for this group when it is located in Nebraska and is certified as meeting the criteria, as a children's hospital, for exclusion from the Medicare Prospective Payment System (PPS). The Department will make operating cost payments calculated at 120% of the peer group base payment amount for peer group 1 (Metro Acute Hospitals)

10-010.03B5 Calculation of Cost Outlier Payment Amounts: Additional payment is made for approved discharges meeting or exceeding Medicaid criteria for cost outliers for each DRG. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $35,000. Cost of the discharge is calculated by multiplying the hospital-specific cost-to-charge ratio determined from the base year cost report times the allowed charges. Additional payment for cost outliers is 60% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 67.5%.

10-010.03B6 Medical Education Costs

10-010.03B6a Calculation of Direct Medical Education Cost Payments: Hospital-specific direct medical education costs reflect the Nebraska Medical Assistance Program's average cost per discharge for approved intern and resident programs. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year and adjusted between rebasing years for inflation using the MBI. To determine the direct medical education payment amount for each discharge, adjusted amounts are allocated to the Medicaid program based on the percentage of Medicaid patient days to total patient days in the base-year, and are divided by the number of base year Medicaid discharges and multiplied by 75%.

NMAP will calculate a quarterly Direct Medical Education payment for services provided by NMMCP capitated plans from discharge data provided by the plan(s). Payment will be the number of discharges times the direct medical education cost payment as calculated in 471 NAC 10-010.03B6a.

10-010.03B6b Calculation of Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from NMAP, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the sum of the operating cost payment amount and the outlier payment amount times 75%.

The IME factor is calculated as follows:

Effective July 1, 2001 to June 30, 2002:

$$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1]1.60$$

Effective July 1, 2002 and thereafter:

$$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1]1.35$$

Base rates will be adjusted by the applicable IME factor.

10-010.03B7 Calculation of Medicaid Capital Related Costs: Medicaid capital-related per diem costs are calculated from base year Medicare cost reports as follows:

1. Routine service capital-related costs - Medicaid routine service capital-related costs are calculated by allocating total hospital routine service capital-related costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed capital-related costs.
2. Inpatient ancillary service capital-related costs - Medicaid inpatient ancillary service capital-related costs are calculated by multiplying an overall ancillary capital-related cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary capital-related cost-to-charge ratio is calculated by dividing the sum of the capital-related costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.
3. Total capital-related costs are equal to the sum of Medicaid routine service capital-related costs and Medicaid inpatient ancillary service capital-related costs.
4. Building and fixtures capital-related costs are calculated by multiplying total capital-related costs times a percentage determined by dividing total hospital building and fixtures costs by total hospital capital costs.
5. The capital-related per diem cost is calculated by dividing Medicaid building and fixtures capital-related costs by the sum of base year Medicaid acute care and bassinet patient days.

Capital costs are calculated by blending the hospital-specific costs per day with the peer group weighted median cost per day over an eight-year period, as follows:

Medicaid Rate Year	Hospital-Specific	Peer Group Weighted Median
July 1, 1995, through June 30, 1996	100.0%	0.0%
July 1, 1996, through June 30, 1997	87.5%	12.5%
July 1, 1997, through June 30, 1998	75.0%	25.0%
July 1, 1998, through June 30, 1999	62.5%	37.5%
July 1, 1999, through June 30, 2000	50.0%	50.0%
July 1, 2000, through June 30, 2001	37.5%	62.5%
July 1, 2001, through June 30, 2002	25.0%	75.0%
July 1, 2002, through June 30, 2003	12.5%	87.5%
July 1, 2003, through June 30, 2004	0.0%	100.0%

10-010.03B8 Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the DRG.

10-010.03B9 Rebasing of Rates: Each prospective rate component will be rebased every three years. Rebasing will be calculated using the most recently final-settled cost report available at the time of rebasing for each facility.

The Department may utilize cost report data that is not final-settled in instances where a final-settled Medicare cost report for a hospital is not available. For example, if two hospitals merge into a single provider entity, and the combined provider entity does not have a combined cost report that is final-settled, the Department may utilize a more recently completed combined cost report that is not final-settled.

10-010.03B10 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1,2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services (with the exception of state owned/operated facilities) provided on or after July 1, 2001, shall not exceed 110% of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B10a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility's final settled cost report.

Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B11: Adjustment of Rates: The peer group base payment amount and the direct medical education payment amount will be inflated annually during intervening years between rebasing using the MBI.

10-010.03B12 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B13 Inpatient Admission After Outpatient Services: A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B14 Readmissions: NMAP adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All NMAP patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

10-010.03B15 Interim Payment for Long-Stay Patients: NMAP's payment for hospital inpatient services is made upon the patient's discharge from the hospital. Occasionally, a patient may have an extremely long stay, in which partial reimbursement to the hospital may be necessary. A hospital may request an interim payment if the patient has been hospitalized 60 days and is expected to remain hospitalized an additional 60 days.

To request an interim payment, the hospital shall send a completed Form HCFA-1450 (UB-92) for the hospital days for which the interim payment is being requested with an attestation by the attending physician that the patient has been hospitalized a minimum of 60 days and is expected to remain hospitalized a minimum of an additional 60 days. The hospital shall send the request for interim payment to the Department of Health and Human Services Finance and Support.

The hospital will be notified in writing if the request for interim payment is denied.

10-010.03B15a Final Payment for Long-Stay Patient: When an interim payment is made for long-stay patients, the hospital shall submit a final billing for payment upon discharge of the patient. The date of admission for the final billing must be the date the patient was admitted to the hospital as an inpatient. The statement "from" and "to" dates must be the date the patient was admitted to the hospital through the date the patient was discharged. The total charges must be all charges incurred during the hospitalization. Payment for the entire hospitalization will be calculated at the same rate as all prospective discharge payments. The final payment will be reduced by the amount of the interim payment.

10-010.03B16 Payment for Non-physician Anesthetist (CRNA) Fees: Hospitals which meet the Medicare exception for payment of CRNA fees as a pass-through by Medicare will be paid for CRNA fees in addition to their prospective per discharge payment. The additional payment will equal 85% of the hospital's costs for CRNA services. Costs will be calculated using the hospital's specific anesthesia cost to charge ratio. CRNA fees must be billed using revenue code 964 - Professional Fees Anesthetist (CRNA) on the HCFA-1450 (UB-92) claim form.

10-010.03C (Reserved)

10-010.03D Payments for Psychiatric Services: Payments for psychiatric discharges are made on a prospective per diem.

All psychiatric services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for psychiatric services which is not a licensed psychiatric hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The peer group base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission, but not the day of discharge.

Mental health and substance abuse services provided to clients enrolled in the NMMCP for the mental health and substance abuse benefits package will be reimbursed by the plan.

10-010.03D1 Calculation of Peer Group Base Payment Amount: The peer group base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year (in accordance with the methodology described in 471 NAC 10-010.03B3, #1, 2, 3) per patient day for all psychiatric free-standing hospitals and Medicare-certified distinct part units. Per diem amounts are weighted by patient days, and the peer group median is determined.

10-010.03D2 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem (see 471 NAC 10-010.03B7).

10-010.03D3 Calculation of Direct Medical Education Per Diem Rate: Hospital-specific direct medical education costs reflect NMAP's average cost per patient day for approved interns and residents. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year, and adjusted for inflation using the MBI. To determine the direct medical education payment amount paid for each patient day, adjusted amounts are divided by the number of base year Medicaid psychiatric patient days and multiplied by 75%.

10-010.03D4 Payment for Hospital Sponsored Residential Treatment Center Services: Payments for hospital sponsored residential treatment center services are made on a prospective per diem basis. Effective January 1, 2002, this rate will be determined by the Department and will be based on historical and future reasonable and necessary cost of providing the service. Payment will be an all-inclusive per diem including all non-physician services.

10-010.03E Payments for Rehabilitation Services: Payments for rehabilitation discharges are made on a prospective per diem.

All rehabilitation services, regardless of the type of hospital providing the service, will be reimbursed on a per diem basis. This includes services provided at a facility enrolled as a provider for rehabilitation services which is not a licensed rehabilitation hospital or a Medicare-certified distinct part unit. The per diem will be the sum of -

1. The hospital-specific base payment per diem rate;
2. The hospital-specific capital per diem rate; and
3. The hospital's direct medical education per diem rate, if applicable.

Payment for each discharge equals the per diem times the number of approved patient days.

Payment is made for the day of admission but not for the day of discharge.

10-010.03E1 Calculation of Hospital-Specific Base Payment Amount: The hospital-specific base payment per diem is calculated as 100% of the median of the hospital-specific base year operating costs for the base year, adjusted for inflation using the MBI from the mid-point of the base year cost report to the mid-point of the rate year (in accordance with the methodology described in 471 NAC 10-010.03B3, #1, 2, 3) per patient day for all rehabilitation free-standing hospitals and Medicare-certified distinct part units.

10-010.03E2 Calculation of Hospital-Specific Capital Per Diem Rate: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per diem (see 471 NAC 10-010.03B7).

10-010.03F Payment for Services Furnished by a Critical Access Hospital (CAH): Effective for cost reporting periods beginning July 1, 1999, and after payment for inpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule, ceilings on hospital operating costs, and the reasonable compensation equivalent (RCE) limits for physician services to providers.

Subject to the 96-hour average on inpatient stays in CAHs, items and services that a CAH provides to its inpatients are covered if they are items and services of a type that would be covered if furnished by a hospital to hospital inpatients.

10-010.03G Rates for State-Operated IMD's: Institutions for mental disease operated by the State of Nebraska will be reimbursed for all reasonable and necessary costs of operation. State-operated IMD's will receive an interim per diem payment rate, with an adjustment to actual costs following the cost reporting period.

10-010.03H Disproportionate Share Hospitals: A hospital qualifies as a disproportionate share hospital if the hospital meets the definition of a disproportionate share hospital and submits the required information completed, dated and signed as follows with their Medicare cost report:

1. The names of at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are eligible for NMAP. This requirement does not apply to a hospital:
   a. The inpatients of which are predominantly individuals under 18 years of age; or
   b. Which does not offer non-emergency obstetric services to the general population as of December 21, 1987.
   c. For a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.
2. Only Nebraska hospitals which have a current enrollment with the Nebraska Medicaid Assistance Program will be considered for eligibility as a Disproportionate Share Hospital.
3. When notified by the Department that the hospital qualifies as a Disproportionate Share Hospital (DSH), each hospital must certify to the Nebraska Medical Assistance Program that it has incurred costs for the delivery of uncompensated care which are equal to or exceed the amount of the DSH payment.

10-010.03H1 Disproportionate Share Eligibility Calculation: To calculate eligibility, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year. Eligibility as a Disproportionate Share Hospital will be calculated using the following data:

1. To determine the Medicaid Inpatient Utilization Rate, the denominator will be the total days as reported on the Medicare Cost Report. The numerator will be the sum of each hospital's Medicaid days, which includes the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made. Only secondary payor days in the MMIS claims file data will be included.

2. To determine the Low-Income Utilization Rate, data from the Nebraska Accounting System will be used to calculate the Low-Income Utilization Rate for State-Owned Institutions for Mental Disease (IMDs). For all other hospitals, the hospital's certified report of total revenue, Medicaid inpatient revenue, cash subsidies, uncompensated care charges, and total inpatient charges minus any disproportionate share payment will be used.

10-010.03H2 Disproportionate Share Payment: Disproportionate share payments will be made one time for each federal fiscal year (FFY) following receipt of all required data by the Department. Payments determined for each federal fiscal year will be considered payment for that year, and not for the year from which proxy data used in the calculation was taken. To calculate payment, proxy data will be used from each hospital's fiscal year ending in the calendar year preceding the state fiscal year which coincides most closely to the federal fiscal year for which the determination will be applied.

a. The Department will make a disproportionate share hospital payment to hospitals which qualify for such a payment under one of the following pool distribution methods.
   (1) Basic Disproportionate Share Payment (Pool 1):
   For FFY03 and succeeding years, the Department will determine a basic disproportionate share payment for eligible hospitals in Peer Groups 1, 2, 3, 5, and 6 as described below.
      (a) Total funding to the Basic Disproportionate Share Hospital Pool will be $5,200,000 annually.
      (b) The payment will be calculated as follows:
         [1] First, each hospital's Medicaid days (which include days from the MMIS claims file data run 150 days after each hospital's fiscal year end, managed care days, and out-of-state days reported before the federal fiscal year for which the determination is made) will be divided by the sum of the Medicaid inpatient days of all hospitals which qualify for a payment in Pool 1.
         [2] Second, the ratio resulting from such division will be multiplied times the total funding for Pool 1 to determine each hospital's payment.
         [3] If payment to a hospital exceeds the disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.
         [4] If payment is reduced to a hospital within Pool 1, the additional funds will be redistributed prorata to eligible hospitals with Pool 1.